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DEVOTED TO THE
DISEASES OF CHILDREN

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CASE VI.—B. M—, aged twenty-four, suffering from primary anæmia and menstrual disturbances. No organic lesion. Hæmoglobin ten per cent., corpuscles 3,000,000 per cubic millimetre. After taking the preparation forty-three days the amount of hæmoglobin remained at ten per cent., but the corpuscles had increased 1,200,000 per cubic millimetre.

CASE VII.—C. V—, aged fifteen, presented the ordinary appearances of the anæmic girl at the age of puberty. No organic lesion. Hæmoglobin eight per cent., corpuscles 2,800,000. The examination of the blood after taking the pepto-mangan (Gude) forty days showed that the hæmoglobin was normal in amount, and that there were 4,000,000 corpuscles to each cubic millimetre of blood.

CASE VIII.—M. M—, female, aged twenty-four; six weeks after ovariectomy; presented a markedly anæmic appearance. Had shown a slight improvement in color after taking Bland's pills for three weeks. These were stopped, and the iron and manganese preparation given. Examination of blood showed eight per cent. hæmoglobin and 3,200,000 corpuscles per cubic millimetre. After forty-eight days the hæmoglobin had increased two and a half per cent. and the corpuscles 1,300,000.

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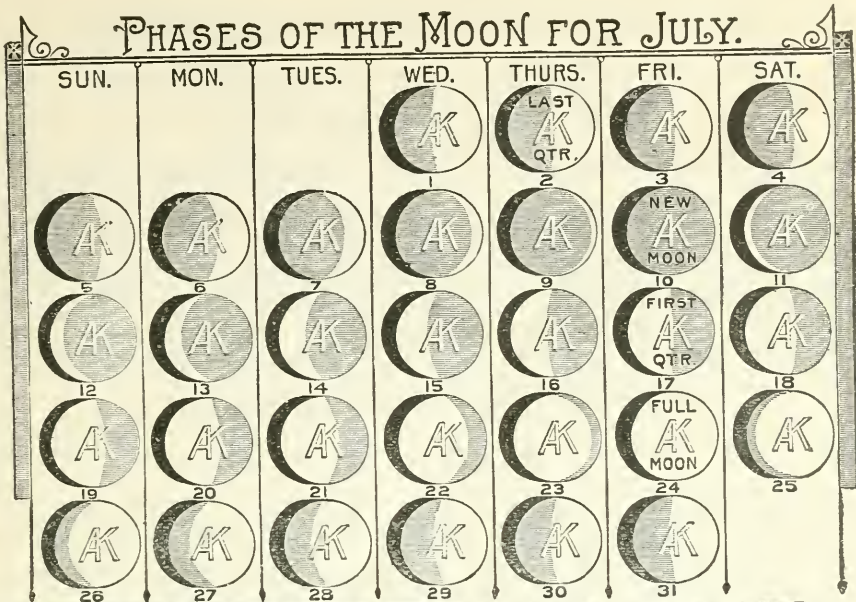
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On several occasions, other foods such as raw meat juice, Mellin's Food, etc., had been tried for a day or two, but had always disagreed. The above diet had, therefore, been continued pretty constantly. For some months after it was first given it had seemed to agree, but recently—since she has been living in the country—she had not thriven on it at all.

A few weeks before I saw her a lump was noticed on the back of the chest, below the left scapula. It was not tender then. There was no history of any injury.

On Examination.—I found her a very pale, weakly baby, weighing only twelve pounds with her clothes on. She had no teeth, her fontanelle was very large, she had marked beading of the ribs, and some rickety deformity of the chest wall. She perspired very freely. There was a hard, painless swelling on two of the ribs, below the angle of the left scapula, probably due to callus, following a greenstick fracture. The extremities were very flabby and thin. The lower limbs were exceedingly tender to the touch, but no swelling of any of the bones could be found.

The heart and lungs were normal, the liver not enlarged, the spleen could just be felt below the margin of the ribs. The motions were large, pulpy and of a dull green color.

The urine was clear and normal looking when seen, but was said to be frequently turbid and reddish. Unfortunately it was not chemically or microscopically examined.

The child moaned constantly, and screamed loudly if touched or even approached by a stranger.

Treatment.—She was ordered Meigs' mixture of cream, milk, lime water, milk-sugar and water; it was to be boiled and given in gradually increasing amounts. The Savory & Moore's "Food" was reduced to two dessert spoonfuls in the day; it was found that unless the bottle was flavored with a little of this the child could scarcely be induced to take any.

Progress.—During the first fortnight the baby steadily improved in appearance, strength and appetite. She took about 30 ounces of the cream mixture each day and gained fully 1 pound in weight.

Relapse.—She was then taken to the country (East coast)—to the same place where she had formerly not thriven—the same treatment exactly being continued. The change of air seemed at once to have a very unfavorable influence on her. She lost her appetite, became irritable again and had unhealthy motions. She also lost weight at the rate of $\frac{1}{2}$ lb. a week, and the tenderness of her limbs returned. On July 31st her urine was found to contain large num-

bers of blood corpuscles. Her parents were advised to bring her back to town as soon as possible.

On August 7th she was brought back. She was found to be in very much the same general condition as when first seen, and to be taking scarcely half the amount of cream mixture that she had formerly taken. There were also several new symptoms. Below each eye narrow dark blue streaks were visible, about the margin of the orbit, and these, on examination, proved to be ecchymoses. The gums were not swollen and there were no petechiae on them, but the rugae crossing the hard palate were swollen and of a dusky red color.

The urine was distinctly red and strongly acid ; it contained a considerable amount of albumin. Under the microscope a large number of red cells, a few leucocytes, a few squamous epithelial cells, and some rounded renal cells were found. There were also several blood-casts seen, in which the red corpuscles were intact, and many composed of their debris ; also several hyaline casts with red corpuscles sticking in them, and a few containing tolerably normal renal epithelial cells. There seemed to be some pain on micturition. The temperature was 97.8° F.

Treatment.—As the case was now clearly one of scurvy, a deserts-^{teaspoonful} of orange juice was ordered every eight hours, the diet otherwise remaining as before. Two days later an emulsion of cod liver oil was ordered (half a teaspoonful thrice daily).

Progress.—Under this treatment the child rapidly improved, so that within six days she had gained fifteen ounces in weight and the tenderness and irritability had, to a large extent, disappeared. The urine had also lost its red color, but it still contained a trace of albumin and showed colored blood corpuscles, a few fragments of blood casts, and amorphous urates under the microscope.

During the following three weeks the improvement continued steadily. The urine became quite normal by August 29th, and remained so. The weight increased so that in 29 days of treatment she gained 49 oz. Grape juice was now substituted for orange juice, and the dose of cod liver oil doubled.

About this time the child was taken for a part of the day to the place in the country which had formerly disagreed with her. The air seemed at once to affect her so that while there she refused to take her bottle ; when, however, she came home at night, her appetite returned and she went on as usual.

After this the improvement was maintained for several months, the infant gaining 4 or 5 oz. each week, looking stronger and hap-

pier and taking the cream mixture well, although still unable to digest plain milk even when considerably diluted. In November, yolk of egg and raw meat juice were added to her diet, and in December, Chapman's Wheat Flour. As there were no longer symptoms of scurvy, the fruit juice was discontinued in the course of the winter.

Relapse.—In the spring of 1895 I saw the child again and found her thin, extremely irritable and tender (especially about the legs), with more signs of rickets but with no hæmaturia, and with no further distinct indications of scurvy. Several of her teeth were being cut and her gums were sore, although not spongy, and this was supposed to be largely responsible for her irritability. For some months this unsatisfactory condition continued; slight improvement being always followed by relapse.

On June 2, 1895, I had again an opportunity of examining her thoroughly. She was now worse than I had ever seen her before—irritable and tender to a most distressing degree, as well as much emaciated. The pain was apparently only present when the parts were touched and it seemed to be in the bones or periosteum, certainly not in the joints. It was much more severe over the sacrum and in all parts of the lower limbs; the toes were so tender that the nurse found it impossible to cut the child's nails. The arms and thorax were also tender, but to a much less extent. The upper gum was slightly swollen, but not dark in color, and there were no ecchymoses. Epistaxis had occurred several times.

The urine was very acid; there was a deposit of amorphous urates and a slight trace of albumin. Under the microscope a good many red corpuscles were found, and a few fragments of blood-casts, similar to those noted previously.

The child was taking practically nothing but the cream mixture (14-16 oz.) flavored with Savory & Moore's Food (a tablespoonful in the twenty-four hours). It was only with great difficulty that she could be induced to take this amount, although she willingly drank water whenever it was given her.

Treatment.—On the following day, June 3, orange juice and potato pulp were ordered in increasing quantities.

Progress.—Within four days the child had improved so much that her nurse thought her better than she had been for two months. She scarcely cried at all now when being washed and dressed, and when left alone kicked about her legs voluntarily as she had not done for long. All trace of blood and albumin had disappeared from the urine. Under the microscope numerous large lozenge-

shaped crystals of uric acid were seen and a few oxalates. The motions were still loose, but more healthy.

During the next three weeks the infant steadily improved, rapidly lost all her unnatural tenderness and took regularly large quantities of the cream mixture, along with six teaspoonfuls, daily, of potato pulp (which she greatly dislikes), and the orange juice as before.

On June 24th she began crying a great deal, evidently from some pain, although the seat of it was difficult to ascertain. The screaming occurred in paroxysms, which returned at frequent intervals through the day and also at night. Her limbs were not at all tender now, but pressure on the back and loins seemed to cause pain.

Next day she was no better. The urine was found to be very acid, pale, turbid, with a trace of albumin. On microscopic examination, numerous pus cells were found, but no blood corpuscles or crystals.

On June 27th she was worse every way. Temperature 101.6. Rapidly losing flesh. Pain evidently very severe, and constantly recurring. Micturition always preceded by pain. Urine contained numerous pus corpuscles.

• June 28th. Temperature 102°. No improvement.

June 29th. As before. Ordered pot. citrat. grs. iii every 2 hours, and tinct. hyoscyam. ʒ v. every 4 hours. This was followed by considerable relief and she had a quiet night. Next day the temperature was subnormal, although there was no change in the state of the urine.

July 2d. Bladder sounded under cholorform; no stone found.

July 3d. Child a little easier, pain less frequent and less severe, no tenderness, gaining in weight. Urine less acid, clearer and containing fewer pus corpuscles.

During the next fortnight the baby steadily improved and the pains ceased. The urine became clearer and there were only a few pus cells to be found; occasionally there were an enormous number of very large brown uric acid crystals, mostly lozenge-shaped.

By August the urine was absolutely normal, and the child was beginning to try to walk for the first time.

During the ten months which have since elapsed the child has continued to thrive, so that she has now evidently got over her tendency to scorbutus.

Remarks.—We had then in this case a baby presenting signs of dyspepsia and malnutrition of scorbutic origin, although without any

pathognomonic symptom of this disease. When she was given a more satisfying and somewhat fresher diet she improved so long as she took plenty of it, but when she lost her appetite under the influence of an uncongenial change of air the symptoms returned, and there were added to them some which were undeniably those of scurvy.

The unfavorable effect of the East coast climate on the child was most unexpected, but was proved over and over again by experiment. When she was taken out of town on the inland side of Edinburgh, on the other hand, her appetite improved instead of falling off.

The complete efficacy of fruit-juice, without any other change in the diet, was very striking—as it often is in such cases.

Another point of interest in the case was the predominance of the urinary symptoms. The significance of haematuria in the diagnosis of infantile scurvy has been insisted on by Dickinson,¹ Gee² and others. This case illustrated further the importance of examining for even microscopic traces of blood in the urine³.

The paroxysmal pain, with lumbar tenderness, and followed by the passage of uric acid crystals, was regarded at the time as probably of the nature of renal colic. This belief has since been strengthened by reading Dr. R. A. Gibbons' interesting paper on that subject⁴.

The pyuria was probably due to pyelitis. I understand from Dr. Barlow that he has met with this condition in cases of infantile scurvy. It is, of course, a recognized symptom of the disease in adults.

1. "Renal and Urinary Affections," 1885, Part 3, p. 1287.

2. St. Bartholomew's Hosp. Rep., Vol. xxv, 1889, p. 85.

3. See L. Conitzer, *Munchener med. Wochenschrift*, 1894, No. 11 and 12.

4. *Trans. Med. Chir. Soc. Lond.*, Vol. lxxix.



A NEW HOSPITAL FOR CHILDREN AT BUENOS AYRES.

By GEORGE MACKERN, M. D.,
Buenos Ayres, Argentina.

THE new children's hospital in course of construction at Buenos Ayres, Argentine Republic, is situated at the extreme Northwest, one of the highest and most open parts of the city. The total space covered by the buildings and gardens is over 25,000 (twenty-five thousand) square yards, or nearly five acres—a magnificent site, acquired some years ago by the *Sociedad de Beneficiencia*, which is a charitable society, conducted entirely by ladies of the upper classes.

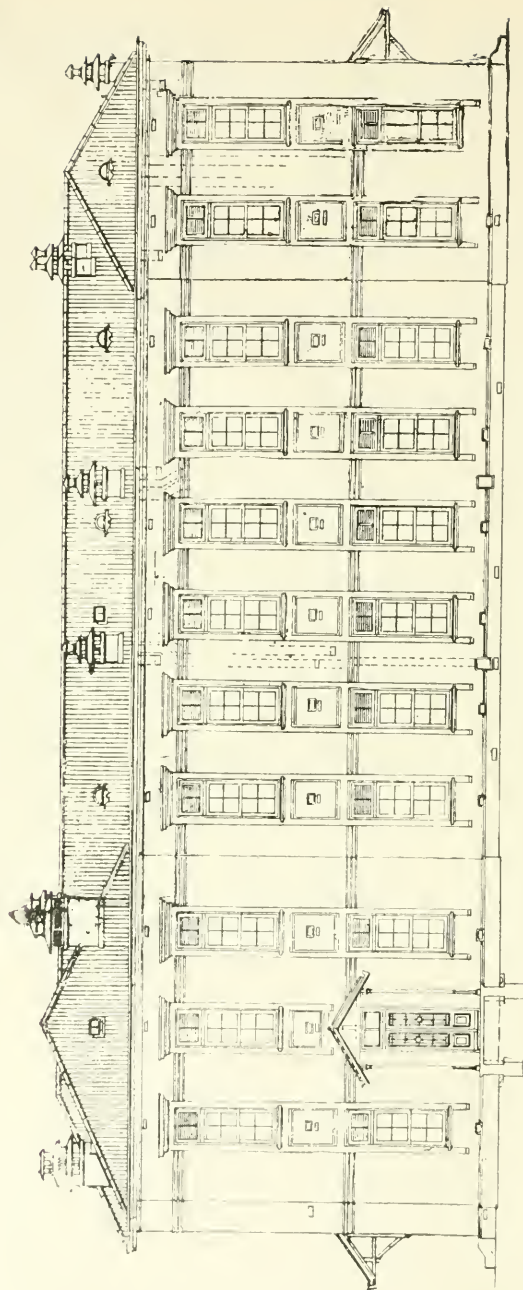
The hospital is eventually to cost one million of dollars (now about £65,000), exclusive of the site, but only six hundred thousand dollars are at present available, and most of this money has been raised by a lottery, the Government also donating two hundred thousand dollars. The architect is Mr. A. Christophersen of this city, who exhibited the plans at the Chicago Exhibition and obtained a first prize.

The hospital is made up of the principal groups of buildings, one including ordinary medical and surgical wards and an operating theatre, and the other comprising separate wards for contagious diseases. Wide avenues of trees and gardens will separate and effectually isolate the one group from the other.

As will be seen from the plans, the system adopted is that of separate pavilions, those of the first group communicating with each other by means of corridors, consisting of an iron roof, supported merely by iron pillars, while those of the second or contagious diseases group are completely separated from each other.

The entrance to the hospital will be through the Administration Block, a three-storied building, with two side wings, enclosing a large airy *cour d'honneur*.

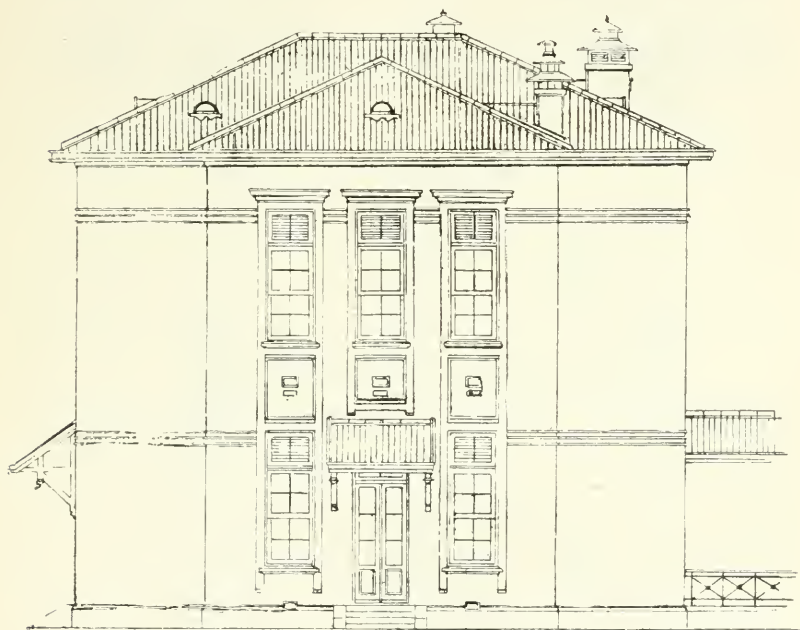
This building contains, besides the ordinary offices for administrative purposes, the out-patient department, which is arranged as follows: a spacious waiting-room, then two small rooms communicating with each other by a small window, and opening into a large and well-lighted consulting-room. The child is undressed in one of the small rooms, goes in naked into the consulting-room, and its clothes are passed through the window into the other small room, where it is dressed again after being thoroughly examined. Arranged in this way, the out-patient department becomes a practical



SIDE VIEW OF THE MEDICAL AND THE SURGICAL WARDS.

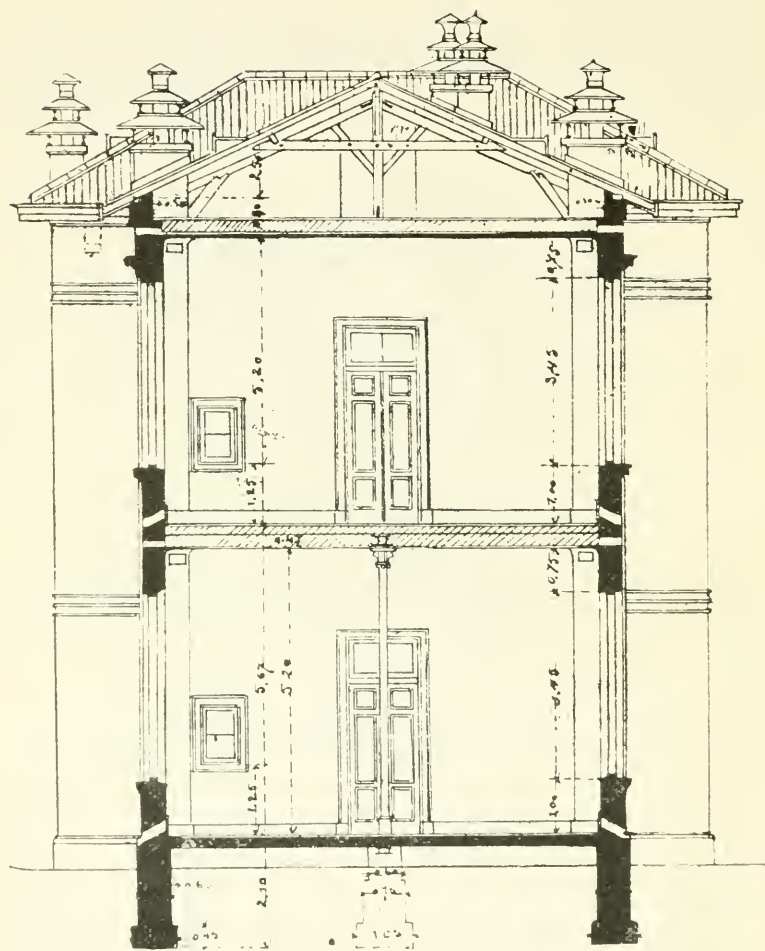
and valuable means for clinical work. The pharmacy and lavatories are all on the same floor. Upstairs are the rooms for the resident medical officer and ten clinical assistants, and quarters for the dispenser and the nurses who, being all Sisters of Mercy, have their own separate staircase, refectory and isolation ward (in case of illness).

The Operating Theatre stands alone in the center, as it were, and communicates by corridors with the wards and administration. The large operating-room is lighted by huge low windows on both



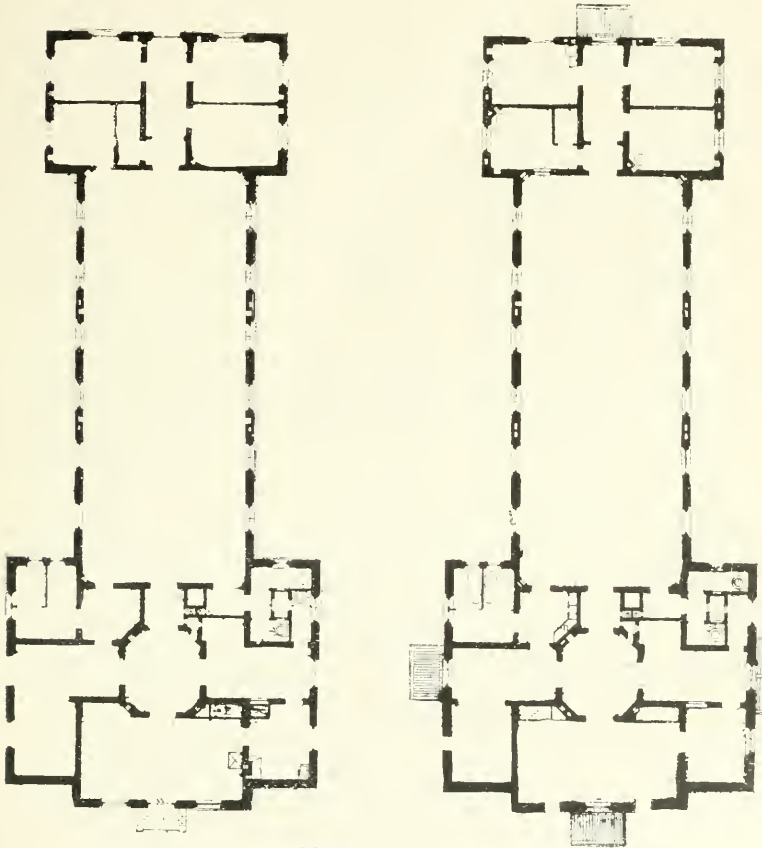
sides; its walls are cemented and the corners rounded off, so that a hose at strong pressure can be directed to all parts and the walls thoroughly washed. Dressings and instruments are kept in specially-designed niches, and the deposits for disinfecting and other fluids are all *outside* the pipes running through the wall into the theatre.

The washing stands are of marble, and so arranged that hot and cold water can be admitted by merely touching a pedal with the foot. The sterilizing apparatus is most complete, the model being that of Geneste & Herscher. There is also a smaller room for



operations, two small wards with beds, and a bath-room—all attached to the operating theatre.

The theatre is connected with the general hot air system run-

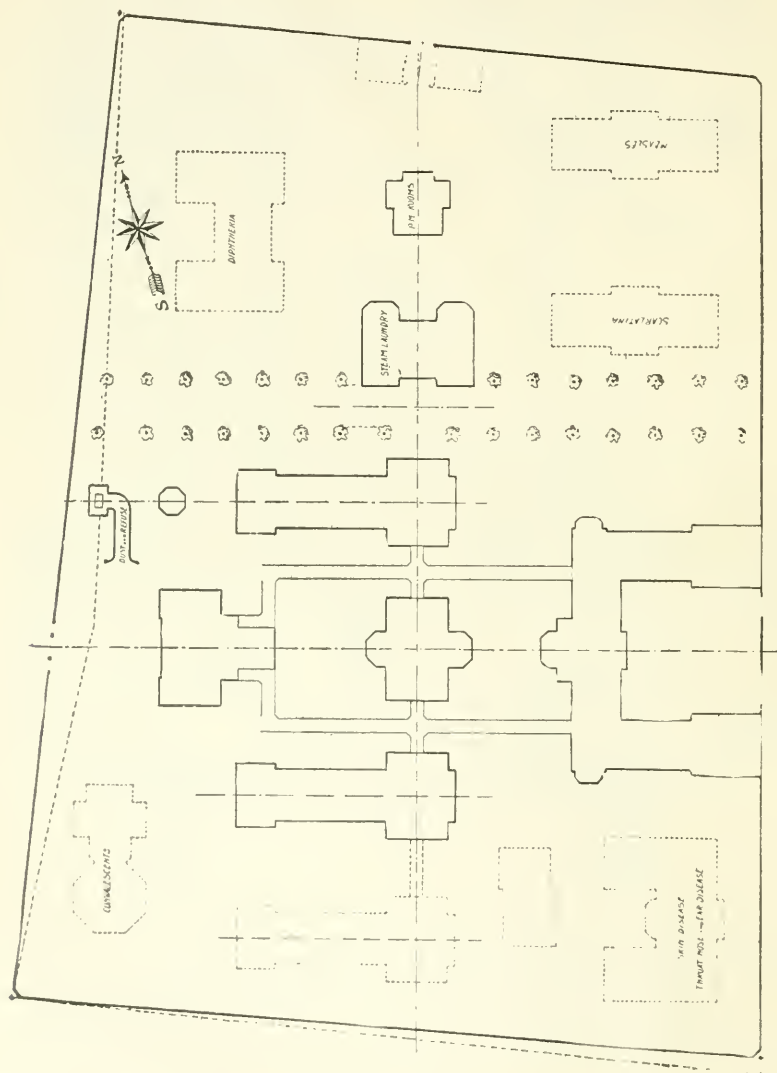


MEDICAL WARDS.

ning through the whole hospital, but the temperature can be raised to 75° or 80° in a few minutes by turning a special tap.

Medical and Surgical Wards are identical in form and size, and consist of two floors, the upper for boys and the lower for girls. Each ward contains twenty-four beds, but in cases of emergency an-

other row of ten or twelve beds can be placed down the middle. Connected with each ward are three isolation-rooms, each containing two beds, for cases which require quiet and separation from the large ward. The baths and lavatories are on one side, and the W. C.'s on the other. There are also a nurse's room, a room fitted



up with lockers for the patients' clothes, and a small hall or vestibule, which is also a dining-room for those able to be up. Light and air are admitted by twelve large sash windows on each side, and the coils of the hot water apparatus are arranged in such a way that in winter all the air can be heated before it enters the wards.

Steam Laundry and Disinfecting Chamber.—These occupy a one-storied pavilion, with the boiler and steam-engine in the basement. The soiled linen and other clothes are passed in by a special entrance to the disinfecting chamber, and from it pass across a screen to an employee, who is never in contact with the others employed on the other side in disinfecting; the disinfected clothes then pass by a lift to the floor above, where they are washed, dried, ironed, mended and sorted out, all in separate rooms. The only exit from the disinfecting chamber is through a bathroom, where the employee is supposed to have a bath and change his clothes on leaving his work.

Mortuary.—A building on the extreme right, consisting of a small vestibule with a place on either side for the bodies, and a good-sized post-mortem room with all necessary appliances. The bacteriological and other laboratories are all in the central administration block.

Kitchen and Service are in a separate pavilion at one end, with servants' dining-hall, stores, pantry, ice chamber, etc., etc. The food for the entire hospital is prepared in this kitchen.

This briefly describes what is now almost completed, but the plan includes also a special pavilion of two stories, the lower for skin diseases and the upper for diseases of the throat, nose and ear. There is also to be built another pavilion for convalescents, to contain twenty-four beds and large, airy recreation grounds.

The Contagious Diseases group of buildings will consist of one pavilion for diphtheria, one for smallpox, and a double one for scarlatina and measles, with separate consulting-rooms.

From what has been said it will be seen that Buenos Ayres will soon be supplied with what promises to be a model children's hospital, containing 340 beds, and, from what I know of the physicians and surgeons attached to it, I look forward to being able to give PEDIATRICS from time to time interesting reports of clinical work and original research.

Llobet at the Rawson, and Castro and F. Perez at the clinical hospitals, are working up a high reputation for Argentine surgery, while Penna, Wernicke, Susuri and Uballes are doing good solid work in bacteriology and clinical medicine.

ANTERIOR DISPLACEMENT OF THE HIP (CONGENITAL).*

By DEFOREST WILLARD, M.D.,

Philadelphia, Pa.,

Clinical Professor of Orthopaedic Surgery, University of Pennsylvania ; Surgeon to the Presbyterian Hospital, etc., etc.

Anterior displacements of the head of the femur from congenital deformation of the acetabulum, or of the head and neck of the femur, are quite rare ; only two or three American cases having been reported. Hence this record.

The patient was a boy, aged 11 years. No history of injury at birth or later. Began to walk at one year of age, but parents were not positive as to whether they noticed any peculiarity of gait until he was three years of age. Gait at present is a decided limp, from shortening of the leg, but the waddle is not characteristic as seen in cases of posterior displacement. There is only a moderate amount of lordosis, since the position of the head of the bone does not necessitate marked accommodation of the spine.

Viewed anteriorly, two inches below the right anterior superior spinous process, and in a line with it, is a hard prominence which rotates in unison with all the movements of the femur. The neck of the bone can also be easily distinguished. The trochanter is more prominent than normal and broadens the limb at this point. The head apparently lies upon the ilium directly above the normal position of the acetabulum ; it does not slide during locomotion. Adduction and rotation can be performed to nearly the usual limits, but abduction is interfered with when the limit reaches ten degrees outside of the straight line. Flexion is normal ; extension slightly limited. The head can be outlined without much difficulty, and the peri-articular muscles all seem in good condition. The head does not lie upon the ramus of the pubes, nor in the thyroid foramen, as ordinarily seen in anterior traumatic dislocations, but is directly above the socket.

Posteriorly, the right buttock is broadened and slightly flattened and the trochanter more prominent.

The boy can stand upon tip toe on the right side, but the leg and thigh are slightly atrophied, being half an inch less in circumference. The distance from the anterior spinous process to the knee is one and a quarter inches less than the left, when the leg is

* Read before the American Orthopaedic Association, May, 1896.

straight; but when the thigh is flexed to the right angle the knees are in line owing to the upward position of the displacement. It is probable that the deformation consists in a false acetabulum above the site of the true one, rather than that the acetabulum is oval in shape.

The motions of the femur nearly approximate the normal, and, as there is no sliding motion, shortening is the only practical deformity. It is difficult to see how any operative interference would be beneficial, since lordosis is slight, and the power of the muscles connecting the trunk with the femur would certainly be diminished by interference. Lengthening the limb artificially is all that is advisable. As this procedure corrects the limp and the interference with locomotion is so moderate, it is difficult to see how a Hoffa or Lorenz operation would improve him.

I have seen a number of cases of variations in the hip articulation which have differed markedly from the typical condition of congenital dislocation. Some of them have very probably been from fractures or dislocations or epiphyseal separations. In some cases the femoral neck has been shortened and even distorted and twisted possibly coxa vara; while in other instances there has been an appearance of an old injury. In the majority of cases the injury has been unrecognized (according to the history), thus leaving the question of pre-natal or puerperal injury uncertain. The first evidence of the condition has been the irregular gait which the child exhibited when commencing to walk; or, perhaps, the disability was not noticed until a year or two later. In the majority of cases the growth of the limb has been so altered that there has been a difference of from half an inch to two inches in length.

When the head of the femur is fairly well confined in its movements upon the ilium, diagnosis is sometimes difficult. It is probable that although the condition has existed from birth, the cause may have been traumatic even within the uterus. In this deformity, as in others, it is quite possible that violent coition during the first month of pregnancy may influence the embryonic mass, especially if the ovum has attached itself in the lower segment of the uterus.

The diagnosis of anterior position of the head of the femur from acute bending of the neck of the femur, as described by WHITMAN (*Trans. Am. Orthopædic Assoc.*), is not difficult.

About the trochanter the conditions are similar. In misplacement, however, the head of the bone can be plainly distinguished in its abnormal position. Trochanteric rotation is altered. Bending of the neck may or may not be associated with rachitic deformi-

ties; yet it must be due to some softening of the bone akin in character.

The trochanter in acute bending is above Nelaton's line, while in anterior displacement it is both above and in front of its normal position. Mutter, of Germany, in 1889, first described this condition, as it usually occurs in children about the age of puberty, probably due to causes similar to those which produce lateral curvature.

LEESER (*Presse Medicale*, Oct. 5, 1895) states that rachitic symptoms co-exist.

Acute bending is most liable to occur in those who have heavy weights to carry, or who are subjected to prolonged standing while in a debilitated condition; but there must be some local fault to cause the deformity, as it frequently occurs on one side.

DRS. RIDLON and PHELPS have both reported cases of anterior dislocations.

In DR. PHELPS' case (*Trans. Am. Orthopædic Assoc. Vol. iv., p. 132*), the child died of acute spinal meningitis one and a half years after treatment was commenced. The specimens showed that the case was one of congenital dislocation, probably in utero, with non-development of the acetabulum. Whether this occurred from traumatism, or from some reflex spasm of the muscles caused by central nerve lesion in early foetal life is uncertain.

KETCH (*Keating's Encyclopedia of Children*) does not believe that the condition is due to injuries at birth.

In Phelps' case, the head of the bone lay in front of its normal position. The leg was shortened and the toes were rotated inward. The acetabulum was angular in shape, small and undeveloped.

My own belief is that traumatism inflicted during delivery is productive of fractures or dislocations to which the plastic anatomy of the infant adapts itself and gives only a moderate amount of subsequent deformity. In breech presentations a hook is frequently placed over the thigh of an infant and strong traction made upon the tissues; certainly sufficient to displace a bone or break the rim of the acetabulum.

The treatment proposed is prolonged extension in bed, followed by the use of an apparatus to continue extension, as recommended by BRADFORD (*Trans. Am. Ortho. Assoc. Vol. iv., p. 308*), the individual being kept under extension in all positions of the limb. For locomotion, a long fixation splint may be used, or a jointed locking and unlocking splint with leg and thigh envelopment. The method

of forcible manipulation during the process of extension probably produces a certain amount of adhesive inflammation.

In RIDLON's case (*Trans. Am. Orthopaedic Assoc. Vol. 2, p. 76, 1889*) the head of the femur lay almost directly below the anterior iliac spine. The leg was shorter than its fellow. Forcible traction by Taylor's extension hip splint was continued in bed for an entire year, after which the child walked upon a long traction splint, the shortening being reduced from three inches to half an inch, although at the time this case was reported continuous traction was still in force and no weight had been borne upon the limb.

In another case which I have recently seen (a girl two years of age), the left leg was three-quarters of an inch shorter than the right one, and she walked with a decided limp. The head was freely movable upon the ilium, nearly an inch, in an upward direction. The trochanter was prominent, but was not displaced backwards. The head of the bone could be distinctly outlined, apparently lying upward and slightly forward.

SPECIFIC URETHRITIS IN VERY YOUNG BOYS.

By BERNARD WOLFF, M.D.,
Atlanta, Ga.

WITHIN the last year I have seen two cases of specific urethritis in very young boys. I append brief notes of the cases, which may be of interest to your readers not only from a professional but also from a sociological standpoint.

CASE 1.—A poorly nourished negro boy, three years of age, was brought to my clinic for treatment of frequent and painful micturition of a week's duration. Examination revealed a penis of unusually large size, with a swollen and oedematous prepuce, from the everted orifice of which a stream of thick, greenish-yellow pus was issuing. A slide was obtained from this, which was found after staining with carbol-fuchsin to be swarming with gonococci.

The mother of the boy stated that she shared her small house in the negro quarters with a family in which there were a number of half-grown girls and that shortly before the boy had begun to complain of pain on urination, she had detected him in the act of copulating with one of these girls.

CASE 2.—A well-developed negro boy, five years old, was brought by his parents for treatment of cystitis that had existed for ten days. There was an almost continuous dribble of urine and great pain and distress in the region of the bladder. A small quan-

tity of pus was obtained by stripping the urethra and stained with methyl-blue. It was found to contain a considerable number of gonococci. The boy's mother expressed no surprise when I informed her of the nature of his trouble and said that she had already suspected it, as the boy slept with a mulatto girl of fourteen and that she had several times been caught in the act of drawing the boy on top of her. When remonstrated with, she had feigned ignorance of the meaning of the reproach. I had an opportunity of examining this girl some time afterwards and found her suffering from vaginitis, presumably of gonorrhoeal origin.

These cases, while not unique, are of sufficiently infrequent occurrence, especially when the disease is contracted by actual sexual connection and not accidentally or intentionally inoculated, to be of interest. They serve to illustrate the extreme precocity of the sexual instinct in the negro.

The Use of Tannigen in the Diarrhœas of Children.—

ESCHERICH (*Centralb. f. d. g. Therapie*, 1896, xiv, 371). Tannigen, a diacetyl of tannin, is insoluble in the mouth and stomach, but soluble in the alkaline contents of the intestinal tract. E. takes for granted, that in spite of the acid reaction of the chyme in infants, there are certain portions of the intestinal lumen, where neutral or alkaline juices are secreted, in which tannigen may be dissolved and do its work. This alkaline reaction is certainly not absent where the intestinal mucous membrane is in a state of irritation, and just in these portions which are diseased can tannigen produce its effects. He thinks it, however, contraindicated in acute inflammatory affections of the bowels, and in the accompanying transudation of serum into the gut. It is least indicated where there is an increased secretion of mucus. Very likely tannigen acts as a disinfectant and subduer of abnormal fermentation, and the formation of toxins, which go hand in hand.

The results in subacute and chronic intestinal catarrhs of children have been very gratifying, mainly in diarrhœas with the discharge of much mucus.

The good results are often noticed within one and two days, and the drug must then be stopped, so as not to produce constipation. In chronic cases it must be given for a longer time. He recommends large doses—0.25 gm. of the powder for children up to one and a half years of age; 0.5 gm. for older ones, given four to six times a day. The powder can conveniently be mixed with the food, as there is no bad effect following it.

The results in acute intestinal catarrhs, and in the beginning of an enteritis follicularis were not quite as good; here it should only be given until mucus appears in the stools.

THE CARE OF THE EAR IN CHILDREN.

By MACLEOD YEARSLEY, F. R. C. S.,

Surgeon in Charge of the Ear and Throat Department, the Farringdon General Dispensary, formerly Clinical Assistant to the Ear Department, Westminster Hospital, and to the Central London Throat and Ear Hospital, etc.

IT is hoped that the time is passed when the general practitioner's stereotyped reply, "The child will grow out of it," to all inquiries by anxious mothers was used as a cloak for his ignorance of aural surgery. If in the present day there are still left a few of the old school who do not believe the teachings of those of a younger generation, the more efficient instruction and the better opportunities enjoyed by modern students of medicine will gradually cause the extinction of old-fashioned notions and a resulting salvation of still more children, who, through want of timely and common sense treatment, would formerly have been doomed to a more or less maimed existence. The discovery of adenoid vegetations of the naso-pharynx by Meyer, of Copenhagen, in 1868, gave the first impulse to a better understanding of some of the troubles which beset the earlier lives of our children, and there are few men more worthy of honored memory than he whose researches have saved many a little one to its parents.

Although the improvement in nursery hygiene and attention to the special senses has been great during the past twenty years, there is still much that is wanting. The practitioner who is responsible for the safety of the child through the tortuous paths of infantile disease must keep a sharp look out for complications which may ruin eye or ear, and a few short directions as to the care of the latter can never come amiss, however frequently they may be repeated.

The two commonest diseases which may ruin the delicate hearing apparatus of the child and handicap him in his future life are Post Nasal Growths and the specific Fevers. For those who want a picture of the havoc wrought by unrecognized adenoids, no better one has been drawn than that by M. Potiquet* of the death of Francis II. of France, the first husband of Mary Queen of Scots. How much of Mary's troubles, how much of such horrors as the massacre of St. Bartholomew, may not have been indirectly caused by the unchecked growth of the post-nasal vegetations? Francis died of meningitis (or cerebral abscess) dependent upon suppura-

* La Maladie et la Mort de Francois II, roi de France.

tive otitis media. Happily modern children are safe from a fate which must have claimed their ancestors by the hundred.

The diagnosis and treatment of adenoids is so well known that further reference thereto is scarcely needed here ; but a few words upon one or two questions that have been much discussed will not be out of place. In the first place, there is the question, Ought we always to operate upon adenoid vegetations? Hernet* has advised postponement of operation unless there is manifest want of development, inaptitude for work, persistent headache, or aural complications, and acting upon this principle he states that he has operated upon only fourteen cases out of 103 seen in eight years. There are many who will doubt the wisdom of this advice. Surely there is a chance of postponing an operation (which, properly done, is attended with a minimum of risk) until too late. One cannot always keep within sight of one's patients, and the flood of the tide is easily missed. Hernet mentions cases which, without operation, grew up tall and strong, *but still continued mouth breathers*, the adenoids persisting for ten years. Now, that so much is known of the respiratory functions of the nose and the evils of nasal obstruction, there can be but little excuse for the exposure of a patient, especially a child, to the dangers of permanent mouth-breathing. Readers of Dr. Sims Woodhead's paper on "The Channels of Infection in Tuberculosis"§ will find another argument in favor of operating for adenoids. It is true that a few selected cases do well under the nasal injection of glycerine of tannic acid, suggested by Dr. Pritchard, but even in those cases the surgeon must be ready to operate if necessary. French, of Brooklyn, has said, "The sooner the operation is performed the better, for there can be no more valuable tonic than that which results from re-establishment of nasal respiration."

Another question which has given rise to much difference of opinion is that of an anaesthetic. There are few cases in which, when an anaesthetic is necessary, gas is not sufficient. In young children the examining finger can often do all the work, and it is rarely that an anaesthetic is required. Personally, I do not consider (and I believe there are many who will agree with me) that one is justified in submitting a patient to the risk of chloroform in operating for adenoids.

The third question to which reference may be made is that of the results of operation. Recurrence is probably due to the in-

* Journ. Laryngol., IX., 1895, p. 456.

§ The *Lancet*, Oct. 27, 1894.

creased growth of small patches of adenoid tissue hitherto kept under by the pressure of the larger growths removed. It has been suggested that the popular method of rapidly operating is to be blamed for this, but rapid need not mean imperfect work. I have elsewhere pointed out that, when the naso-pharynx is clear, a final scrape should always be given to remove any point of lymphoid tissue which cannot be felt. The proper carrying out of after treatment will have influence in reducing the number of cases of so-called recurrences, for, as Dr. Dundas Grant has indicated, recurrence of symptoms does not always prove recurrence of growth. The proof of the good effects of the removal of adenoids is quickly manifested in children, and for the rapid improvement in the rate of body-growth, I would refer the reader to a paper by Castex and Malherbe in *La Presse Medicale*, March 31, 1894.

Turning now to the exanthemata, the amount of mischief still allowed to go on from a want of proper attention to the ear during their course is scandalous to a profession which prides itself upon its progress. Otitis media suppurativa occurring during or after the specific fevers is pre-eminently preventable, and yet two-fifths of the cases of middle-ear disease claim measles or scarlet fever as a cause.* The exercise of a due amount of care of the nose and throat during the course of those diseases should materially reduce the number of these cases. Both measles and scarlet fever are particularly liable to accompanying throat complication, a complication tending especially to involve the nose and Eustachian tubes. The tumefaction, together with the increased and tenacious secretion, quickly blocks up the latter, and gives rise to a retention of catarrhal products in the tube and tympanic cavity. This retention is further helped, as pointed out by Dr. Walker Downie,§ by the dorsal position of the child in bed. The patient is rendered still more liable to the condition by the presence of adenoids or hypertrophied tonsils.

Now, the implication of the throat cannot be prevented, but the blocking of the Eustachian tubes and the retention and consequent suppuration in the tympanum can, and that by simple methods. In older children encouragement to a frequent use of the handkerchief will relieve the throat and nose of the collection of thick, tenacious mucus, and gentle politzeration will help to keep the tympanum properly ventilated. In infants who are too young to use a handkerchief properly, Politzer's douche must be employed alone, and

* On the care of the ear during the course of the exanthemata, by Walker Downie, M.B., *British Medical Journal*, Nov. 24, 1894.

§ *Locus cit.*

this applies also to patients whose posterior nares are blocked by adenoid growths. These means, combined when necessary with lavage of the naso-pharynx, will prevent or quickly relieve the ear-ache caused by intratympanic retention of catarrhal products, and in every case of scarlatina or measles in which the throat is implicated they should not be neglected or postponed until called for by aural symptoms.

It is important also that an examination of the ear be made from time to time, for considerable mischief may occur before attention is directed thereto, especially in young children. If suppuration be already established before the ear is examined, especially if there be a sudden rise of temperature, the membrana tympani should be incised at once. This minor operation should not be delayed, as a slit-like incision in the membrane heals very quickly, whereas if the pus be allowed to make a way through the drumhead for itself, the patient will in all probability be left with an unhealed perforation, with all its many possibilities. Incision is also indicated when there is acute pain in the ear, which is unrelieved by Politzerization. Incising the membrana tympani ("myringotomy") is a perfectly simple and safe procedure, provided it is properly done, but there can be no doubt that a great deal more harm may ensue by neglecting it than by performing it in a clumsy manner. Before its performance it is well to antisepticise the meatus with warm perchloride solution (1 in 2,000) and to instill a few drops of a 10 or 20 per cent. solution of cocaine. The best instrument to use (and many have been designed for the purpose) is a shouldered myringotome, as the shoulders prevent any damage being done by an unskilled hand. The "tympanotome" suggested by Dr. W. F. Core* is also a good instrument. The head of the patient requires to be firmly held, the membrane must be made distinctly visible by good illumination, and it should be perforated in the inferior posterior quadrant, where the bulging is usually the most marked. Inflation will then clear the tympanum, and gentle syringing with warm antiseptic solution will be all that is required until the opening is healed.

It is not, however, only of the care of the ear during other diseases that I would speak; with children it should be guarded as carefully during health as at other times. Mothers and nurses often do harm through ignorance, and the general practitioner has opportunities from time to time of giving them hints, the most apparently

* *New York Medical Record*, Nov. 9, 1895.

trivial of which may be of value. I have seen ears damaged by unskilled efforts made at cleaning the meatus with a pin or the objectionable spoon-shaped appliance sold for the purpose, and those in every-day charge of children should be impressed with the fact that gentle wiping with a soft towel is all that is necessary. It is a good practice to put wool in a child's ears during its ablutions, for cold water may cause not only pain but inflammation, and, when the meatus is wetted, careful drying should never be neglected.

This use of wool in the meatus is especially necessary when the child is bathing in the sea or taking sea-water baths. The action of such bathing in causing aural exostosis is well known.

Of the reprehensible habit of striking children on the head or "boxing the ears," nothing need be said. Nature has gifted the human child with an ideal place for correction, and parents do not seem to realize the importance and delicacy of the organs contained in the skull or the grave mischief that may be caused by blows in that region.

In conclusion, one may ask whether, considering the care bestowed upon the sister sense of sight, there is any reason why an equal amount of attention should not be paid to hearing. Of the relative importance of the two senses one cannot speak, but the ear is quite as delicate as the eye, and there is no more excuse for neglecting to prevent a suppurative otitis media or to treat it when present than there is to allow a purulent ophthalmia to run its course unchecked.

Treatment of Malaria in Children.—MONCORVO (*Rio de Janeiro-Centralbl. f. d. g. Therapie*, 1896, xiv, 248) says that the administration of quinine is difficult, both on account of its bitter taste, and the intolerance of the baby's stomach. The studies of the author related to *helianthus annuus*, methyl blue, phenocoll and asaprol. *Helianthus annuus* (the sunflower) inhabits Peru, but is now frequently raised in gardens. His researches were made with an alcoholic extract of this plant made from the leaves and blossoms. In 61 cases of malaria in children from the ages of one month to twelve years, it was given in doses of 1-6 gr. in 24 hours. The results in most cases were prompt, and not followed by any bad after effects. In a few cases where quinine had been taken without any result, the effects from this drug were satisfactory.

A CASE OF SYPHILITIC (CONGENITAL) ULCERATION OF THE LARYNX AND INTERSTITIAL PNEUMONIA.

By GEORGE CARPENTER, M. D.,
London,

Senior Physician to Out-Patients, Evelina Hospital for Sick Children, London.

MARY E. S., aet. 13 mos., was brought to the out-patient department at the Evelina Hospital on October 29, 1894, by her mother, who stated that she had "bronchitis."

The mother had been delivered of ten children, but five of these were still-born; she had never had any miscarriages. All of the children had thrush, "which passed through them, but did not extend below the buttocks." None of her children suffered from "snuffles"; but the subject of these notes had considerable mucopurulent discharge from the nose, and the mother owned that the child had been troubled with this since she was three months of age, at which time "a rash first broke out round her mouth and then passed to her bottom, but did not extend as low as her knees." She was taken to Guy's Hospital at this time and was given gray powders.

On Examination.—The head was small, measuring $15\frac{1}{2}$ inches in circumference, and the anterior fontanelle widely open. Her mother said she was "very knowing, always laughing and talking in her little way at home." Whilst I was examining her she had an attack of laryngeal spasm. The crowing was not loud and noisy, as with healthy vocal cords, but was dysphonic. Her mother then volunteered the statement that "ever since she had first been taken bad she had crowing on and off." The mouth was extensively scarred at the angles, and the sides of the cheeks and the chin were invaded.

The right upper lobe of the lung was dull to percussion, but little information was obtained from an examination of the lungs, as a laryngeal whistle was audible all over the chest.

There was an eruption on the buttocks and vulva, consisting of papules, varying in size from a pin's head to a small split pea. These had an excoriated look, and were red in color. On the backs of the upper part of the thighs were stains, varying from a pin's head to a pin puncture, and of a dusky hue.

She was treated for syphilis. A few days after her first appearance at the hospital she died somewhat suddenly.

Autopsy.—Larynx. The epiglottis and ary-epiglottic folds were

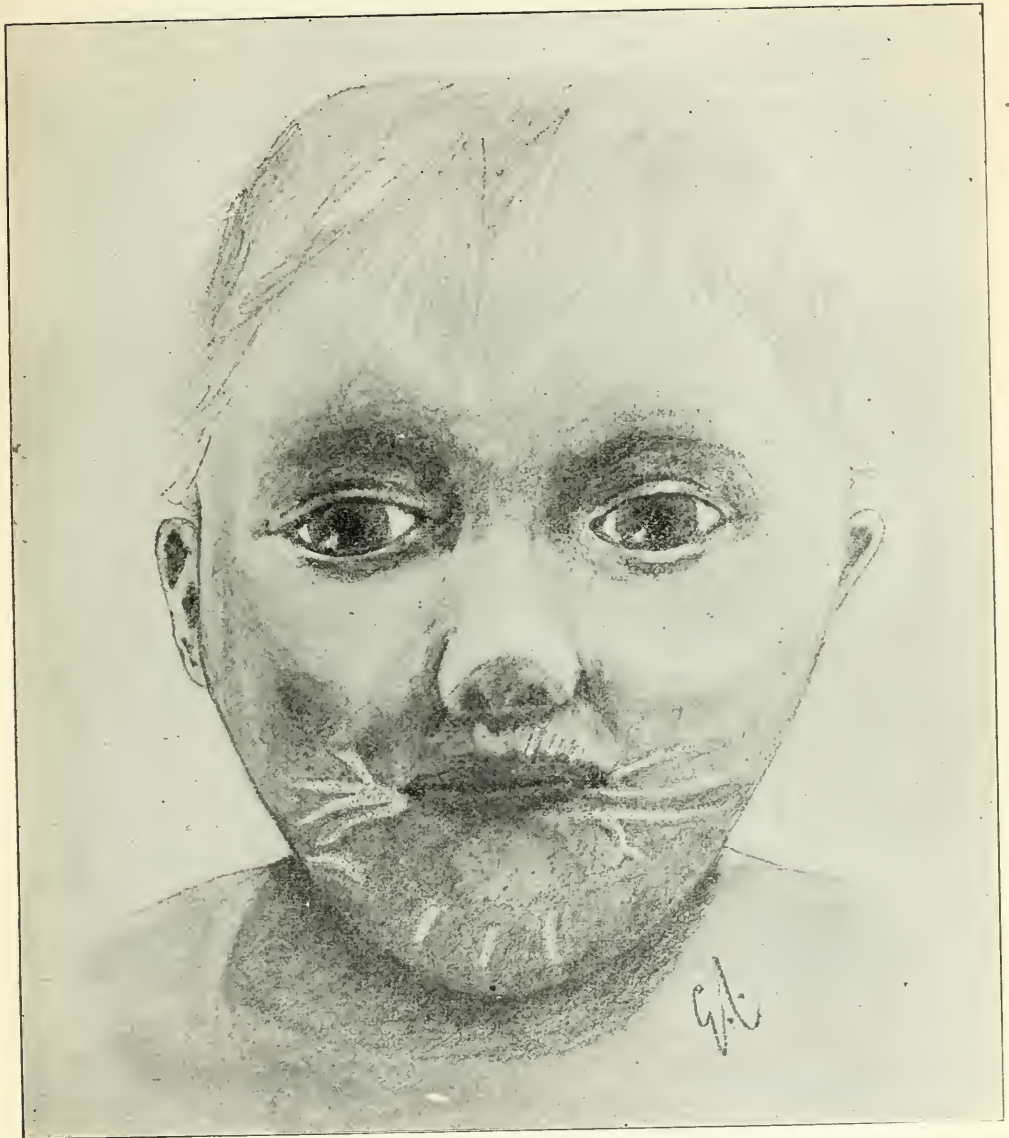


FIG. 1. Scarring of Mouth and Chin. (Congenital Syphilis.) Aet. 13 months.

much swollen. The drawing shows the trachea and larynx opened up in the usual way—the parts have been opened out forcibly.

There was extensive ulceration of both vocal cords, the larger being on the left side, the edges of the ulcers being ragged and their bases rather deep. Both ventricular bands were also ulcerated, the ulceration extending to the ary-epiglottic folds—this was much more marked on the right side than on the left, as is seen in the drawing. The under surface of the epiglottis had a mossy



FIG. 2. Syphilitic Ulceration of the Larynx. Aet. 13 months.

appearance, and when the organ was opened out for the purpose of sketching, deep fissures came in view.

Lungs.—Somewhat recent adhesions were found on the right side. The whole of the upper lobe on the right side had a grayish, slightly granular appearance, and was quite solid. Neither air nor fluid could be squeezed from its cut surface, and it could not be readily broken up by the thumb nail. Some delicate strands of fibrous tissue were seen in it. The other lobes were perfectly healthy.

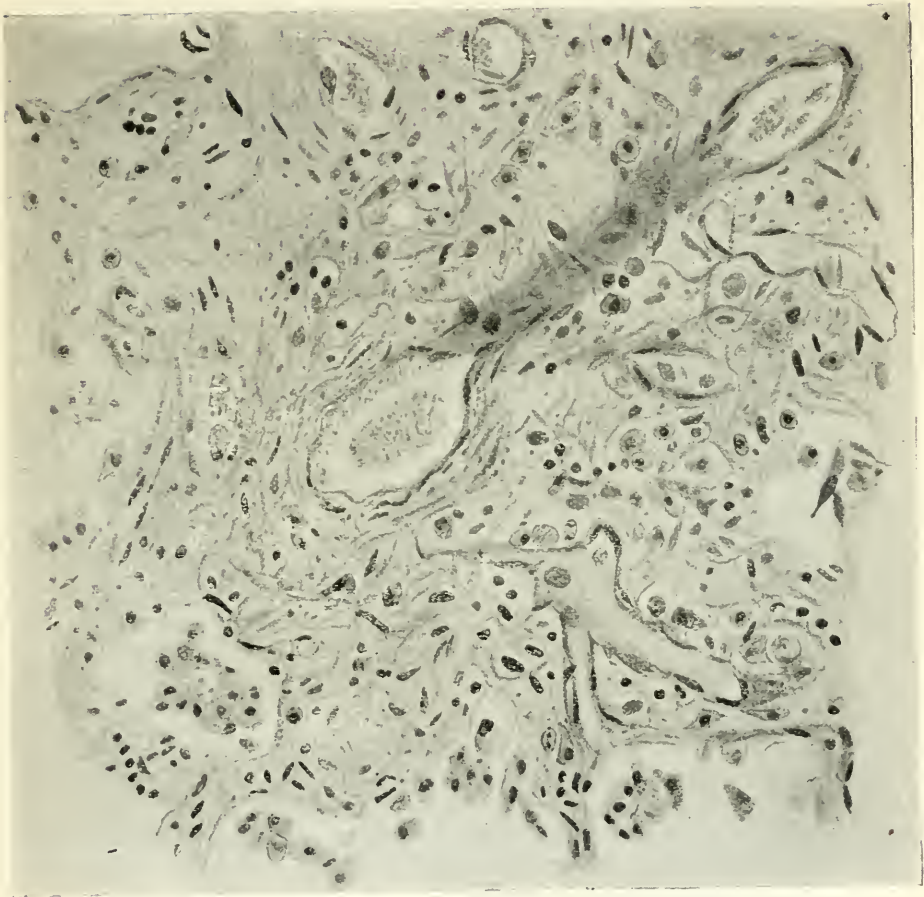


FIG. 3. Interstitial Pneumonia. (Congenital Syphilis.)

A microscopical examination of the consolidated lung revealed the following changes :

There was bronchial catarrh, peribronchial fibro-nuclear thickening, and here and there fibro-nuclear outgrowths invaded the bronchial tubes, with varying impairment of the channel.

The air vesicles were stuffed with catarrhal products, and their walls were mostly thickened. Areas of interstitial pneumonia were found all through the microscopic sections, the fibro-nuclear tissue, which was plentifully supplied with new vessels, invading the air vesicles in all directions. Irregularity in size of the air vesicles was a feature—they were for the most part compressed in varying degrees, and only occasionally a dilated vesicle came in view.

The septa were slightly thickened, as also the pleura, and there was perivascular thickening.

The microscopic drawing here given shows the interstitial changes very clearly.

Intrauterine Crying (Vagitus Uterinus).—W. BRULL (*Wien. clin. Wochenscher*, 1895, viii, 683) reports this case: It was a twin birth. After labor pains had lasted two days, the midwife in attendance had frequently introduced her hand into the uterus for the purpose of facilitating the extraction of the twin presenting by the breech. B., who had been summoned for assistance, on entering the room heard a crying which emanated from the uterus of the woman in labor. The crying was distinctly audible at a great distance, even in an adjoining room. The midwife mentioned that this had lasted, with long intervals between, for three hours. Extraction of an asphyxiated, but later resuscitated, infant was performed. The other twin, which was greatly underdeveloped, was dead when extracted. The conditions for the possibility of the vagitus uterinus he declares to be: first, that the placental circulation must have ceased; second, air must have entered the uterus; third, the amniotic fluid must have been absent, or so distributed in relation to the mouth and nose as not to interfere with breathing. He furthermore calls attention to the medico-legal aspect of the case.

Editorial.

RECENT PROGRESS IN THE TREATMENT OF WHOOPING-COUGH.

OF all the minor ailments to which children are prone, none is so distressing to experience or so painful to witness as whooping-cough. Every contribution to its therapy, therefore, which is based on considerable experience, is liable to be favorably entertained and given a trial. Yet, year after year, and experiment after experiment, we find ourselves as impotent therapeutically in the presence of the disease, either to stay its progress or cut short its course, as we were a decade or a generation ago. Not long since it was believed and stated by a great many writers that we had found in bromoform the medicament which would rob pertussis of its harassing features and prevent the occurrence of disease to which it predisposes. If we may judge from a retrospect of the literature the promise of its efficaciousness has not been fulfilled, and we are as far to-day from a specific in whooping-cough as we ever were.

The results claimed by some writers for certain drugs in the treatment of this disease are quite remarkable. For instance, FISCHER, employing a method originally suggested by Binz (*Berliner klin, Wochenschr, No. 39, 1895*), has had astonishingly good results from the administration of quinine; results which he believes are not to be obtained by any other plan of therapy. In 27 cases in which it was tried in all except in three its beneficent results, reduction in number of the paroxysms, diminution in intensity of the spasm and the like, were to be seen after the third or fourth day. In one case in which the pertussis was complicated with broncho-pneumonia, administration of quinine was soon followed by a diminution in number of the attacks from 30 to 10 a day, the intensity of the attacks greatly modified and the course of the disease greatly abbreviated. In doses of one and one-half grains for a child a year old and pro-

portionately for children older and younger, the writer thinks we have in quinine the most valuable medicament and one which can be relied upon to influence the disease beneficently.

Evidence which tends to corroborate the claims made for quinine has been furnished by Clemens, who has made extensive use of it during several epidemics of pertussis. Whenever it cannot be administered by the stomach on account of irritability of the latter, or from constant vomiting attendant on the paroxysm of coughing, he administers it, and with equally satisfactory results, per rectum.

The virtues of belladonna to mitigate the severity of pertussis are widely known. ESCHLE (*Therapie der Gegenwart*, No. 8, 95) recommends that it be combined with antipyrin and that twice as much of the latter be given as the former. It is a fact verified by universal experience that children are proportionately tolerant to belladonna as they are antipathous to opium, so that therefore moderately large doses of antipyrin are given. The writer believes that after seven years' experience with infusion of belladonna leaves and antipyrin, he is justified in saying that this form of therapy is the most reliable means at our disposal.

The statement of Celli, that vaccination often cuts short an attack of pertussis, is undoubtedly true in many instances, but the suggestion that it should be employed therapeutically has never been received with much favor in this country. BOLOGNINI has put it to a test, however (*Journ. de Chir. et de Therap. in 1895*), and considers that it is worthy of trial in children that have not been vaccinated. Unless other claims for its recommendation are forthcoming, it is safe to say that it will never get far beyond the confines of him who recommends it.

The number of medicaments, devices and therapeutic make-shifts proposed for any disease is proportionate to the unresponsiveness of it to therapy; so that in incurable disease their name is legion. In almost every case some form of air cure, or water cure, or walking-in-the-grass-with-bare-feet-cure plays a conspicuous part. Whooping-cough is no exception to the rule. ULMANN is the latest advocate of the fresh air cure (*Munch. med. Wochenschr*, No. 48, 1895). His experience would seem to warrant a trial of this method of treating whooping-cough, but in private practice it would be impossible to carry it out in this country.

PRACTICAL NOTES.

Therapeutics of infants and children have enjoyed, or suffered from, their fate like "books" and those of adults. They have had their stages between the era of dull and ignorant prescribing and that of impotent and conceited nihilism. But neither a deluge nor an absence of drugs make a physician, when by themselves alone, to the welfare of a single individual or the community. * * * The ailments of children are but rarely complicated, and a single diagnosis tells the whole story. If it be not made, it is perhaps best for the practitioner not to attempt much doctoring and for the patient to be left alone. For, happily, most diseases have a tendency to get well, either completely or partially, and many will run a more favorable course when not meddled with.

This does not mean to say, however, that I discourage treatment even in such ailments as run a typical course extending over a number of days or weeks. On the contrary, I am opposed to the practice—much too common—of those who do not, for instance, wish to interfere with a whooping-cough because it finds its natural termination after several months. This is true, but many of the children find their natural termination also during these months. Every day of whooping-cough is a positive danger. A lobular pneumonia which occurs in the second or third month of the disease, and proves fatal or terminates in phthisis, would have been prevented if the original affection had been removed or relieved by treatment. A physician advising no treatment in such cases as terminate unfavorably in this manner ought to be punished in the state of the future.

Nor do I approve of the practice of "meeting symptoms when they turn up." My responsibility is not lessened by busying myself with subcutaneous injections of brandy when a collapse has set in which I ought to have foreseen and prevented, or by giving digitalis

on the fifth or sixth day of a pneumonia, the pulse is flying up to 160 or 200. Anybody can perform that sort of perfunctory expectant treatment, extending from the first call to the writing of a death certificate.—A. JACOBI.

Mastitis in the Newly Born.—The swelling and secretion of the gland may last a week or two when undisturbed. After it has been squeezed out ever so gently, a new secretion will be invited and continue five or six weeks. Then pressure of any kind must be avoided. It is barely possible that it may not be injurious, and that a gentle inunction of warm oil, which is so commonly used, may do no harm. But as a rule every sort of pressure occasions an attack of inflammation and, maybe, suppuration. Though an abscess be ever so small it is sufficient to destroy all or a part of the mamma forever—a serious misfortune in a female. A swelled mamma must be left alone. Applications of cool or warm water, the cloth being well pressed out and covered with oil-silk and cotton, or flannel, or of a mild lead wash, will answer well. Also applications of iodide of potassium dissolved in glycerine, one part of the former in two to five of the latter, are excellent. Extract of belladonna may be added to advantage. When suppuration is unavoidable, the incision must not be delayed. It ought to be made at the greatest possible distance from the nipple, and directed towards it, so as not to cut the main milk ducts.

Indurations remaining behind require frequent and gentle inunctions of an iodoform ointment (iodoform, ℥ii; ol. bergamont, ℥iv; adip. suilli, 3 vi to x), or iodoform collodion, to be applied with a brush twice every day (iodoform, 1; collodion, 10 to 20), in such a manner that only those scales of the application which are found peeled off from the skin have to be removed before a new layer is applied over the dried-up previous application. A very mild galvanic current of from two to six elements, conducted through the induration by means of soft sponge electrodes moistened with salt water, has rendered me good services in many cases.—A. JACOBI.

Incontinence of Urine.—The great variety of the causes of incontinence of urine requires tact and discrimination in the selection of remedies. General anaemia and muscular debility indicate a diet carefully selected for its nutritiousness and digestibility. * * *
 * Attention must be paid to the capacity of the bladder. * * *
 The sigmoid flexure and the rectum must be empty at night. * * *
 * Muscular debility of the neck of the bladder requires general

and local stimulation. Strychnia (gr. 1-40 to 1-16), suppositories of extract of nux vomica, the fluid or solid extract of ergot or the interrupted electrical current are indicated.

Whenever there is oxalic acid or sugar or an excess of urates and phosphates in the urine, the source of the disturbance must be attended to. Vesical catarrh, nephritis and calculi have their own indications. Hyperaesthesia of the body of the bladder requires belladonna or its alkaloid. In many cases a single evening dose of extract of belladonna (gr. $\frac{1}{4}$ to $\frac{3}{4}$) or sulphate of atropia (gr. $\frac{1}{100}$ to $\frac{1}{75}$) answers well, sometimes to an unexpected degree. Bromide of potassium (gr. vi to xxv), camphor (gr. ii to v), extract humuli fluidum (℥ iv to x), or the elixir humuli (3 i), given at bed-time, answer a similar purpose.

Causes of reflex irritation located in the vagina, penis or rectum require local correction—vaginal catarrh, polypoid excrescences, phimosis, intestinal worms, anal fissure, irritable bladder or urethra, masturbation, etc., etc.—A. JACOBI.

Tubercular Meningitis.—A preventive treatment only may be expected to do good, if anything will. Constipation must be overcome. Eczema and other lesions of the surface should be healed. Their presence is a constant source of danger, both by reason of the opportunities afforded for a direct invasion of microbes, and of the irritation and swelling of lymph bodies. These, when found, must be removed by internal treatment, massage, ointments (green soap, iodide-lanoline mixture), or enucleation. Nasal catarrh should be immediately relieved; its persistence is a cause of "scrofulous glands," and, possibly, of secondary tuberculosis, and also of direct invasion of germs through the patent orifices of the lymph vessels at the base of the cranium and the extra-dural tissue. The best general preventive treatment of infants and children with a predisposition to tubercular meningitis, rendered probable by hereditary taint and by suspicious symptoms, consists in the regulation of the diet and hygiene: animal food mostly, daily cool or cold bathing, with vigorous friction, open windows, exercise, cod liver oil during the cool and cold months, arsenic in regular small doses, and pure guaiacol (or the carbonate of guaiacol) for many months in succession through a course of years.—A. JACOBI.

Society Report.

REPORT OF THE FOURTEENTH CONGRESS FOR INTERNAL MEDICINE, HELD AT WIESBADEN APRIL 8 TO 11, 1896. (*Der Kinderarzt*, 1896, vii, 73).

GREAT interest was manifested in the report, "On the value of medicinal antipyretics," which was read by Prof. Kast (Breslau) and Prof. Binz (Bonn).

Prof. Kast said that the number of antipyretics had increased to about 48-50, and most of them were being used systematically as antipyretics. In answering the question whether the reduction of temperature was beneficial or not, a number of experiments had been made. Walter had found in the Pasteur institute that animals which had been inoculated with pathogenic material, would live longer in the incubator (three days longer if inoculated with the pneumococci) than those which were exposed to the ordinary temperature of the room. Similar results were obtained by Loewi and Richter, who inoculated a number of animals with infectious material, which was 100 times or more stronger than that used on another series. Fliehne also experimented on three different series; one series of animals was placed after inoculation in an ice box, the second in the temperature of the room, and the third in an incubator. Of the three series, the condition of the latter was the best, and the duration of life diminished from the incubator towards the ice box. Somewhat similar were the results of Muller (Breslau) in observing the energy of growth in the bacilli of typhoid fever. This experimenter discovered that the duration of regeneration of these bacilli at 37.5°C to 38.1°C was 32 minutes, at 38.1° to 39.5°C , $37\frac{1}{2}$ minutes. Their virulency diminished according to the rise in temperature. Kast has personally experimented on infected animals, and found that those protected with immunizing serum were benefited by its action, particularly when overheated, but he had not made any studies on the chemical action of the antitoxins during a raised bodily temperature. Phagocytosis was not influenced by a high temperature. The interchange of matter was influenced by overheating. The alkalinity of blood decreases during fever, and remains diminished even when the bodily temperature has been reduced. Litten has claimed that a

parenchymatous degeneration of the organs was produced by fever. It is true that a fatty degeneration is induced by overheating, but a longer time is necessary for its accomplishment than Litten has found. As a therapeutic measure, K. would very much recommend the cooling bath. He would, however, in very sensitive people, occasionally substitute for the bath medium doses of quinine. All other antipyretics only have a symptomatic nerve effect. Prof. Binz spoke about quinine, which to him seemed the most prominent antipyretic. Thirty years ago it was believed that its action was on the nervous system, but it has been proved that quinine had (1) a marked poisoning influence on the amœbæ, and its action was greater on these than upon the cell element of the human body. (2) The antifebric power of quinine is not dependent on the central nervous system and the circulation, hence the assumption was that the cause of malaria was a lower organism, which proposition was brilliantly vindicated. Upon this disease breeder, the malaria-plasmodium, the action of quinine is concentrated, and by destroying this organism it diminishes the enlarged spleen, which is characteristic of malaria.

To determine the question, how quinine could reduce fever in other diseases, there have been various experiments made, for example: those of Gurgensen and Holzaeger. The result was that quinine was believed to act antipyretically by reducing the number and the work of the leucocytes, whose appearance always induce a heightening of the exchange of matter. According to Kobert, quinine also reduces the W. and S. separation in the urine, both during health and in fever. Quinine acts as an antipyretic by its influence on cells, and acts as well on the leucocytes as on the organic cells, reducing their ability to absorb oxygen and using this for the purpose of raising the temperature. Quinine is a special and general antipyretic. The author reminds us that he had introduced the treatment of typhoid fever by baths, quinine and alcohol, in the seventies.

(2) Salicylic acid favors an increase of the blood temperature, in the vapor bath both an increase of uric acid, and an increase in the number of leucocytes.

(3) Antipyrin (also antifebrin and phenacetin) produce their action through the brain. In insolation (Aronsohn and Sachs) quinine has no power, salicylic acid very little, while antipyrin promptly reduces the temperature. It favors an increase of uric acid, an equalization of the urates, an increase of heat production in the body, and an increase of heat rays.

(4) Tannin, which is greatly opposed to bacteria, probably has the same action as quinine.

(5) Alcohol, where it influences temperature, does so only by decreasing it. Experiments on dogs, and its effects in puerperal cases, gave the best results; but how is a reduction of temperature following large doses of alcohol produced? According to Binz's experiments (1870) the nervous system may be excluded. The heart is stimulated by alcohol, which enables it to force the blood current to the surface of the body, where it comes in contact with the external temperature, and is thus cooled off. To this is added the antiseptic quality of the alcohol, which is antagonistic to the poison of the bacteria of putrefaction. Through its chemical action, also, a post-mortem rise of temperature does not take place. Furthermore the diuretic effect of alcohol is to be considered, which is particularly of use in the rapid elimination of toxins, in the absence of diuresis in fevers. The ingestion of water is also necessary to flush the kidneys, whose ducts have been opened by the alcohol.

Leubuscher (Jena) read a paper, entitled: *Diseases of the circulatory apparatus in conjunction with diseases of the nervous system in childhood.*

The author had been struck by the great number of cases showing disturbances of the heart and the circulatory system in idiotic children, of which he had found very little in literature. His observations are of two kinds.

First, he had under treatment two cases of infantile cerebral paralysis, with hypertrophy of the heart. It might be surmised that the paralysis was secondary, due to a primary heart disease, but in both cases the previous history did not reveal a primary disease of that organ, and the author is therefore bound to assume that the heart disease was a secondary condition, following the brain lesion.

In the other cases, the original disease was a diffuse brain trouble. Most of them presented vaso-motor disturbances of the hands and feet. These members were always cold, even in the warmest seasons; frequently decided disturbance of the heart's action, and also marked change in the area of heart dullness was noticeable. With a pulse of 130-140 to the minute, arrhythmia was often present, which was similar to that found in neurasthenia; each change in the heart's action was distributed over 8-10 pulse-beats. These irregularities did not, however, run parallel with the physical condition. The amount of the hypertrophy of the heart was usually only small, but distinct, and the heart sounds generally clear. As a reason for these hypertrophies we may look to the

vaso-motor disturbances, as they were a hindrance to the circulation, and affected particularly the left ventricle. In weak-minded children there may be formed quite early an arterio-sclerosis. Many of these simpletons were the victims of great polydipsia, and the greatly increased imbibition of fluid could not be without some influence on the vessels. Another cause for heart hypertrophy in these cases was masturbation.

Intubation in Diphtheria Patients Before and After the Antitoxin Treatment.—J. BOKAI (*Centralbl. f. d. g. Therapie*, 1899, xiv, 244) from August, 1890, to July 1, 1895, performed 763 intubations, of which 268 recovered. Among these were 90 intubation cases, of which 45 were treated by antitoxin.

Concerning the duration of intubation, the following statistics are gathered by different reporters: Mount Bleyer (in 189 recoveries) extubated definitely on the fifth day in 79.3 per cent. G. Beer (in 30 recoveries) on the fifth day in only 64.5 per cent. Prof. V. Ranke on the eighth day in 73.5 per cent. Before the introduction of antitoxin B. had in 673 intubations 223 recoveries (one-third), and after deducting eight cases, which had to be tracheotomized subsequently, 215 were left, of which 82.3 per cent. were extubated at the end of the fourth day, 62.7 per cent. on the third day, and 19.5 per cent. between the third and fourth day. The average of all his intubation cases was 79 hours.

In the 49 recoveries during the serum period, the extubation was done in 77.26 per cent. at the end of the second, and in 86.35 per cent. at the end of the eighth day, in 90.89 per cent. at the end of the fourth, and in 93.16 per cent. at the end of the fifth day. A table of comparison, furthermore, teaches us that after the first twenty-four hours 5.63 per cent. more cases could be extubated, and on the second day 19.86 per cent. more than before the introduction of the serum treatment, and that also the average duration of intubation was eighteen hours less in the cases inoculated with the anti-diphtheritic serum.

In his tracheotomy cases during the serum period, he was able to remove the canula during the first ten days in 80 per cent. of all his cases, and he expresses the opinion that one is not warranted to follow the oft-repeated rule that a secondary tracheotomy must be performed when a final extubation cannot be done at the end of the fifth day, if at that time no sloughing can be demonstrated.

Abstracts.

THE CLINICAL DIAGNOSIS OF DIPHTHERIA.

P. DEUCHER (*Correspondenzbl. f. Schw-ärzti*, 1896, xxv, 481). In a preface Dr. Sahli gives it as his opinion that a well-schooled physician is able in most cases to diagnose, even without a bacteriological examination, by simply observing the clinical symptoms, to distinguish true diphtheria from all similar affections, and that the diagnosis of diphtheria is, if anything, made too infrequently rather than too often.

The table compiled by D., from which his deductions are drawn, contains 146 cases. The figures in parenthesis indicating : those to the left the number of cases, those to the right the positive finding of Loeffler's bacillus :

A—PHARYNX.

- I. Diphtheria with typical pseudo-membranes (75—75).
- II. Anginas without the typical diphtheria deposit.
 - (1) Punctiform diphtheria of tonsils.
 - (a) without stenosis of larynx (4—4).
 - (b) with stenosis of larynx (11—11).
 - (2) Angina lacunaris (6—0).
 - (3) So-called streptococcus pseudo-diphtheria (1—0).
 - (4) Angina catarrhalis.
 - (a) without stenosis of larynx (5—3).
 - (b) with stenosis of larynx (26—16).
 - (5) Angina necrotica, etc. (3—1).
- III. Normal tonsils (15—8).

B—LARYNX AND TRACHEA.

- I. Croup with demonstrable presence of membrane (77—76).
- II. Croup without demonstrable presence of membrane (27—7).

From an analysis of these cases, Deucher comes to the following conclusions : True clinical diphtheria of the pharynx with presence of typical pseudo-membrane, particularly if scarlet fever cases are excluded, agrees nearly always with the etiological conception of Loeffler's diphtheria. The punctiform diphtheria shows the same coincidence with the bacteriological finding as true diphtheria. Clinically this form is only to be confounded with angina lacunaris on superficial observation, and is sharply defined from the latter ;

the small specks or points being situated on the elevated surface of the tonsil, not in the lacunae; also in that these points cannot be expressed, but must be torn off, as little bits of the mucous membrane being only removable with the latter itself. The angina lacunaris usually contains no diphtheria bacilli, and can be further distinguished from punctiform diphtheria by the test above referred to. The so-called streptococcus pseudo-diphtheria can also be differentiated clinically from true diphtheria, first, by the yellowish color of the deposit; secondly, by the property it has of dissolving and crumbling, while the diphtheritic pseudo-membrane remains for a long time of a tough consistency.

This streptococcus angina with deposits is, on account of its rare appearance, except as the so-called diphtheria of scarlet fever, only of subordinate interest. The separation of a scarlatinal pharynx necrosis from true diphtheria is only possible by a bacteriological examination.

The presence of diphtheria bacilli in a harmless appearing angina catarrhalis, or, indeed, on normal tonsils, is not excluded. The previous history, presence of diphtheria or croup in the neighborhood, and presence of stenosis of the larynx, must be taken into consideration. The appearance of true pseudo-membrane in the larynx and trachea is usually accompanied by the Loeffler diphtheria bacillus. In true pseudo-membranous croup of the larynx the presence of diphtheria bacilli on the tonsils can often be demonstrated, though these may not be diseased or only slightly so. Even when neither in the pharynx nor larynx pseudo-membrane can be proven to be present; pseudo-membranous croup can be discriminated from pseudo-croup by means of the previous history and the course of the disease. In the clinically diagnosed pseudo-croup there are usually no Loeffler bacilli present. Negative results of a bacteriological investigation do not always warrant the positive exclusion of true diphtheria. Diphtheria bacilli may be demonstrated in two-thirds of the cases, particularly when present on the tonsils, by the dry preparation.

TREATMENT OF RHINITIS IN INFANTS.

VOHSEN (*Memorabilien*, 1896, xl, 35) says that nasal catarrh in the infant is a serious condition. There are two things to be borne in mind in its treatment—the removal of the secretion and the therapeutic indication for the nasal mucous membrane. It is necessary for the physician to determine by careful inspection whether the catarrh is unilateral or bilateral. If the first is the case, a careful

examination of the inside of the nasal cavity must be made, which can be done where a rhinoscopic examination is not feasible, by passing a very thin oiled probe, wrapped with cotton (after having previously cocainized the nasal membrane with a 1 per cent. solution of cocain) carefully along the nasal cavity in a horizontal direction, to prove the absence of a foreign body, or some other obstruction. It is well to measure the depth to which the probe will enter in both nostrils, and should this reveal a marked difference in the two, it is better for the non-expert to meddle no further with it. In such cases there are usually found foreign bodies, tumors, congenital bony closures of the choanae or atresia of the passages, which can only be diagnosed and operated upon by the specialist. Then follow the examination of mouth and pharynx. Abnormally small and high jaw-bones are often found in infants, and point to a narrow nasal skeleton, which needs very careful treatment. Enlarged tonsils, less frequently a voluminous tongue, may be the cause of obstruction to nasal breathing. The pharyngeal tonsil is seldom found hypertrophied in infants at the breast. This will hardly be possible to determine by an examination with the finger, owing to the narrowness of the passages, aside from its being an uncertain and rough method.

A safer and very satisfactory way of gaining knowledge of any obstruction in the post-nasal space is the following: A piece of rubber tubing of the proper size is introduced into the entrance to one nostril, without closing the other one. The tube should be of a size to fill the nasal opening. Now blow carefully into the tube, but desist if any resistance is felt to the entrance of air. In that case apply a piece of cotton soaked in a 1 per cent. solution of cocain to the bottom of the nasal cavity, and try once more to force air into it. Should this be impossible even now, with moderate force, the probability is that an obstruction is present in some part of the nasal passage, whose removal must be effected by surgical means. Should you, however, be able to force air through, the mucus present will generally be forced out of the opposite nasal orifice, during the child's efforts at resistance and its crying, and a thorough cleansing is thus obtained. Now you may apply a tampon of cotton soaked in a 3 per cent. solution of boro-glycerin to the presenting clean membrane. Where there is tendency to an eczema at the nasal entrance, this must be combated early by applications of boro-lanolin after each cleansing. This form of treatment has the advantage that it can be carried out by the parents, which is a necessity where success is to be attained. The nose should be cleaned out in this manner frequently during the day, particularly before

each feeding. The seeming probability of infection of the middle ear by this method is very slight. The Eustachian opening in the infant lies at about the level of the hard palate, and probably is closed during the elevation of the soft palate. Only in later years it is found higher up.

CONCERNING INTESTINAL ANTISEPSIS.

H. STEIN (Vienna) (*Centralb. f. d. g. Therapie*, 1896, xiv, 321) says that the presence of an immense number of microbes in the normal intestine has been for a long time an incentive for studying their significance in relation to the digestion and their bearing on diseases of the intestine. Bacterial processes in the intestinal canal are nearly universally conceded now to be absolutely essential to normal digestion. An intestinal antiseptic is, therefore, only to be directed against either a pathological numerical increase—that is, an abnormal and dangerous evolution of otherwise harmless microbes, or against specifically dangerous species of the same.

Without entering into bacteriological details, the following microbes have been demonstrated at present in the intestinal tract. The author enumerates here, at length, the various bacilli and the conditions in which they thrive, and says the following about treatment :

The means which can be employed to rid the intestinal tract of these diseases breeding immigrants are :

1. Their removal by means of purgatives or enemata.
2. The destroying or cutting off the development of these carriers of infection.
3. Rendering innocuous the toxic substances formed by them.

The influence exerted on the number of remaining intestinal microbes after the use of purgatives is astonishingly great.

If there are not unsurmountable contra-indications to the use of energetic or mild purgatives, the disinfection by way of the upper intestinal tract should be begun with the administration of strong purgatives. If the infection is situated in the lower intestine, repeated enemata are then, of course, the proper treatment.

A medicine possessing both a disinfecting and purgative quality is to be preferred to others. Therefore calomel has up the present taken precedence of all others.

Bouchard has, in the following sentences, indicated the qualities which an ideal intestinal antiseptic should possess :

1. It should be somewhat difficult of solution, so as to act throughout the whole extent of the intestinal canal.

2. It should be in the form of an exceedingly fine powder, that it may come in contact with the whole canal and incorporate itself with the contents of the same.

3. It should be administered in small but frequently repeated doses, so that it may, in spite of the peristaltic action of the bowel, be present in sufficient quantity in every part.

From the fact that the contents of the bowel in the adult are 5-6 kgr., the remedy must be of such a nature that large quantities of it may be introduced without jeopardizing life. There are a number of drugs of this kind on hand. Amongst the easily soluble disinfectants in proper cases, there are the organic and inorganic acids, for example, muriatic acid, lactic acid, benzoic acid, then corrosive sublimate, and other metallic salts. Phenol, resorcin, chloroform water, etc. Amongst the more difficultly soluble substances we have calomel, iodoform, naphthalin, A and B naphthol, etc. Of substances which become decomposed only after entering the intestine, there are bismuth salicyl, salol, betol, tri-bromphenol and others. There are two other circumstances which have a bearing on the development of intestinal bacteria, and which may be taken advantage of for therapeutic purposes. These are the chemical reaction of the feces, and their consistency. In an acid and relatively solid medium, the power of development of these micro-organisms is considerably diminished. Thickening the consistency of the feces by the administration of opium, therefore, may produce a notable decrease of bacteria, in comparison with their number in liquid stools.

The success of an antiseptic treatment of typhoid fever is at times really remarkable. To this disease calomel seems particularly well adapted, and if given in the very early stage in doses of 0.4 to 0.6 grm. a day, divided in ten to twelve doses, it at times seems to have an abortive effect on the disease, changing its whole course to an extraordinary mild one.

Altogether unsatisfactory, however, are the results of treating cholera by internal antiseptic measures up to the present time. Bouchard's successes with iodoform (gr. i) and naphthalin (gr. v, pro die), as well as those of others with salol and allied remedies, have not been sustained by later observers. More satisfactory results were obtained by antiseptic treatment of abnormal fermentation of the contents of the intestines, which leads to an increased formation of gas or acid, and through the latter to increased peristalsis and diarrheal discharges. It should not be forgotten, however, that in using such measures it is absolutely essential to remove first the noxious products of fermentation and its agents by purgatives

(salines, calomel or castor oil), at the same time regulating the diet according to the cause of the fermentation, whether dependent on the albuminates or the carbohydrates, and restricting nourishment to a minimum.

In meteorismus, due to abnormal fermentation, one must bear in mind to cut off all food which is apt to ferment, never neglecting the previous thorough evacuation of the sour contents of the gut and the administration of anti-fermentative drugs. For this purpose the well-known carminatives, as kummel, peppermint, cinnamon, anisseed, etc., are useful. In a large number of cases of intestinal catarrhs bacterial influence plays a causative role, for in part chemical irritation is produced by the condition of vegetation of the bacteria. Stale meat, bad fish and vegetables, or rotten fruit, may be the initial cause of the catarrh. In cases of marked infectious intestinal catarrhs, the toxins generated by the microbes are the leading causes. To this class belong, aside from the infectious febrile duodenal catarrh (Icterus), also some intestinal diseases, which are similar to typhoid fever, and particularly the accompanying diseases of the intestine during general systemic infection.

In cases of chronic bowel diseases those remedies are applicable, which can, through their insolubility, be introduced in large quantities into the gut, without giving rise to poisonous symptoms, such as combinations of bismuth salts, tannic acid preparations, and drugs like rathania, colombo, coto, etc., wherein the anti-putrid properties of tannic acid, and such like ingredients, will lessen fermentation and disintegration.

Much less effective, and confined to narrower boundaries, is the antiseptic treatment in diphtheritic and croupous diseases of the intestines.

RESEARCHES ON THE SEPTIC-PYÆMIC INFECTION OF THE UMBILICAL CORD IN THE NEW-BORN AND ITS PROPHYLAXIS.

M. COHN (*Centralbl. f. d. g. Theurapie*, 1896, xiv, 307) reports the following cases :

CASE I. Boy, aged 14 days. Labor and childbed normal ; on the second day of birth the umbilical cord was retied by the midwife ; it came away on the fourth day. On the fifth day there appeared a reddening and swelling of the left hand, which rapidly spread to the forearm, with fever. On admission to the clinic there was found some slight pus formation on the navel, and a fluctuating abscess on the left forearm, with a surrounding deep infiltration.

Healing took place after two months. When the child was 49 days old he had an attack of severe intestinal colic, with grass-colored, slimy stools, and fever; the navel extruded, became painful, and then discharged pus. Phlegmonous abscesses appeared on the navel, which soon healed through phlebotic suppuration. A sound could now be passed for about 4 cm. in an upward direction under the abdominal parietes.

CASE 2. Male child, 15 days old. Labor and childbed uneventful. The umbilical cord dropped off on the fifth day, leaving behind a stump of about 2 cm., which had to be retied a number of times. On the fifteenth day of birth there appeared swellings on the left maleolus and leg; on the seventeenth day they were noticed on the buttocks, scrotum and foreskin. The abscess on the leg was opened; next day reddening and swelling of the thigh, body and upper extremities (phlegmonous erysipelas), together with symptoms of acute peritonitis appeared, which led to death. Autopsy revealed a seropurulent peritonitis, originating in an umbilical phlebitis. Streptococcus infection was the cause of sepsis. C., in view of these cases, would ask the question: What form of treatment in the toilet of the umbilical cord should be adopted? It seemed to him that we should strive to exclude every form of microbes from the wound, and try to prevent putrefaction of the cord (autoinfection). It should, therefore, be impressed on the midwife to employ the most rigid asepsis, as regards the umbilical cord. The prevention of mechanical injuries through lacerating or straining it should be insisted on, as also its becoming soiled from the lochial discharge. The child should be powdered before attending the mother, and, where puerperal disease is present, it should be isolated. To employ antiseptic measures before the cord has fallen off is superfluous, nay, it may be mischievous, on account of the danger of resorption. The author calls attention to the following points, in order to prevent possible putrefaction of the cord:

1. The umbilical cord should be cut off as short as possible, leaving a stump of about 6-8 cm., and where the cord can be tied lower down even of 1 cm.

2. To ward off all pathogenic microbes by the use of an occlusion bandage (Dohrn) and delaying the bath until the child is seven days old. C. emphasizes the difficulty of applying and maintaining such a dressing in place in general practice, and points out the danger of an ill-fitting bandage.

3. To hasten the mummification of the cord by using loose dressings, which permit the warm air of the room to circulate freely,

and not to use impermeable dressings, which necessitates their change whenever they have been casually wetted, and that the stump of the cord be not, as is occasionally the fashion, enveloped in an oiled linen rag.

Experiments with different dusting powders have led to the conclusion that sugar is directly antagonistic to the object in view ; that alum, though hardening the outer surface, has no power to influence exsiccation of the deeper layers, and therefore does not hasten mummification ; that tannic acid, both in the form of powder or in concentrated solution, is likewise inefficient. Neither is C. convinced of the favorable influence of painting the stump with a solution of nitrate of silver of the strength of 20 per cent., nor of the use of borated starch, dermatol, salicylated starch or wood charcoal. The value of these powders can only lie in their power of acting to a certain point, as antiseptic coverings in the early stages of decomposition.

Lastly, C. insists upon postponing the full bath of the new born until the cord has dropped off, or even until after the navel has healed, for the reason that the daily bath interferes with the drying process and may possibly become the carrier of pathogenic microbes. At the first immersion of the child in the bath, which is unavoidable, he recommends the addition of some permanganate of potassium.

FOREIGN BODY—PLUM SEED—IN THE ŒSOPHAGUS : PERFORATION INTO PLEURAL CAVITY.

C. W. RICHARDSON (*Nat. Med. Rev.*, 1896, vi, 17) reported the following case :

The child was four years old. Eight days before the patient was brought under observation it was said to have swallowed a plum seed. The child was well nourished, and active for its age. The mother states that while feeding her child with preserved plums she observed that there was considerable difficulty and then inability to swallow the food.

On succeeding days the inability to take food was followed by rapid emaciation, great restlessness and indications of febrile reaction. The desire to take food and drink was constant, and all efforts on the part of the little one were in vain. Food was immediately ejected and liquids returned through the nasal passages.

It was emaciated, showing marked evidence of a septic condition. The examination of nose, pharynx and larynx gave negative result with regard to the possible location of a foreign body. It was interesting to note the little one's effort to aid in every way in

these examinations. The inspection of the pharynx and larynx was rendered somewhat difficult on account of the great amount of pus that was constantly welling up apparently from the œsophagus. When the child was given water to drink it was interesting to note that it was immediately regurgitated through the nostrils; the child continuing to drink with the stream of pus and water returning into the glass from which it was drinking. The column of water evidently passed onward to the seat of obstruction and then returned up the pharynx and through the nasal chambers. It now became evident that the seat of obstruction was high up in the œsophagus. At the first attempt to pass a small sound, after passing about three inches below the cricoid cartilage, the sound was firmly arrested. The breath had the sweet alcoholic odor of sepsis.

The next day the sounds were passed without difficulty and without meeting any obstruction; nevertheless the obstruction to food and drink was as great as ever. On account of the possible location of the foreign body, of the inability at this second examination to locate it, and from the desperate condition of the child, it was decided that endoœsophageal or external operations were not to be considered. The child died early Tuesday morning.

Postmortem.—Rigor mortis was moderate and the body emaciated. The thorax was opened in the usual manner. Left side of thorax was first exposed. Left pleura, lung, pericardium and heart were normal. Right pleura discolored and filled with pus. Right lung collapsed. On exposing œsophagus it was found to be intact throughout its whole course. It was then divided at the diaphragm and dissected away. On raising the tissue up, when between about the third and fourth dorsal vertebræ, the seed dropped into the right thoracic cavity. It was not possible afterwards to locate exactly through which of two rents in the œsophagus the foreign body came through. It is quite evident that the irritation of the seed set up an inflammation of the œsophageal wall which terminated in the formation of an abscess which ruptured into the pleural cavity.

EXPERIENCE IN THE CURE OF TUBERCULAR PERITONITIS BY OPERATION.

J. ISRAEL (*Centralbl. f. d. g. Therapie*, 1896, xiv, 243) reported four cases of cure by operative measures of tubercular peritonitis, three in children of the ages of 4 to 7 years, and one in a girl aged 20 years. In the case of the children the diagnosis had been made before the operation. They were all operated relatively early in the disease, at two weeks, at one month and at three and

a half months from the first appearance of the illness. In all three cases was found a very disseminated eruption of nodules, involving all parts of the peritoneum, with only a small amount of fluid effusion. In every case 10-30 grm. of iodoform in oil (10 per cent.) was poured into the peritoneal cavity before closing it.

1. In a boy four years of age was found at the laparotomy, an oedematous condition of the muscles of the abdomen from the umbilicus downward; the peritoneum was thickened and sowed over with miliary tubercles, presenting a picture of intense peritoneal tuberculosis. An intestinal fistula remained after the operation, which however closed in a few months. Increase in weight $7\frac{1}{2}$ pounds. The case was under observation for $16\frac{1}{2}$ months subsequently.

2. A boy of six years of age was operated on three and one-half months from the first appearance of symptoms. Very high fever was present before operation. The mesenteric glands and the intestinal loops were covered with nodules, some of them the size of a cherry pit. Improvement after 36 days. A second laparotomy was done on account of a suspicion of tuberculosis, in which it was ascertained that all of the tubercles had vanished without leaving a mark. Recovery. Under observation for 17 months.

3. A seven year old boy. Operation three to four weeks after beginning of trouble. A very extensive tubercular peritonitis was discovered. Recovery; though in this patient the lungs were also affected.

In the case of the girl, 20 years of age, there was found, along with the tubercular peritonitis, a tuberculous swelling of the size of an apple, situated in the ascending colon. An anastomosis was made between the ileum and colon, followed by the pouring in of 40 grm. of a solution of iodoform in oil (10 per cent.). Recovery. The size of the tumor diminished to that of a walnut. Observation was continued for 7 months after the operation.

THE STUDY OF CEREBRAL-PNEUMONIAS IN CHILDHOOD.

VON HOLDHEIM (*Deutsche med. Wochenschr.*, 1896, xxii, 85). There is a group of acute fibrinous pneumonias of childhood, which are ushered in by severe brain symptoms (restlessness, coma, delirium, cephalagia and vomiting), presenting during the first days the picture of an acute meningitis. Rilliet and Barthez describe a pneumonie cerebrale; Ziemsen, Steiner, Jurgensen, Thomas, Henoch and Gerhard agree with them. These intense nervous symptoms

are attributed by these authors partially to the high fever, and partially to a peculiar susceptibility of the individual to nervous excitation. The changes in the lungs are often not demonstrable until after the fourth or fifth day. Even the most pronounced changes in the lung tissue frequently are obscured by the nervous symptoms. Henoch believes that many so-called recoveries from meningitis in childhood are due to a mistaken diagnosis, the cases having been fibrinous pneumonias with severe cerebral symptoms. As a differential point he mentions that in a true meningitis the cerebral symptoms are not only present in the initial stage, but continue more or less unabated to the day of death. The author describes five cases of cerebral pneumonias, which appeared in an epidemic form, which were, with one exception, brought to the Krankenhaus Friedrichshain from the same district of Berlin. In one of these cases there was no positive diagnosis possible during the first six days. Abnormal temperatures, facial expression, coma, delirium, grinding of teeth, all pointed towards meningitis, until on falling of the temperature the lung symptoms came to the fore, and the diagnosis of a cerebral pneumonia was assured. The site of infiltration in all of the five cases was with preference in the right lung. Pneumonias of the apex, however, usually produce severe cerebral disturbances (Thomas, Jurgensen).

The treatment pursued was : Sherry, daily, one or two baths of the temperature of 35-36° C., with cold douches (for reducing the temperature and stimulating the nervous system) ; by these measures a visible good result was at once accomplished.

CONGENITAL DOUBLE PENIS.

H. KUTTNER (*Beitraege z. klin. Chirg.* 1896, *xv*, 364) had knowledge of only one unquestionable case of double penis up to this time, namely, the one described by Acton and Velpeau. This reported case, however, has one defect ; it gave only the description of the external appearance of this anomaly in the living subject, and there could only be surmises as to the important question, whether there was present also a duplicate bladder, and what position the urethrae occupied towards each other and the bladder. Of much greater interest, therefore, is the description given by Kuttner of the anatomical preparation of a double penis in a newly-born child. The duplication involved the external sexual organs in all their parts, while all the internal urinary and sexual organs were developed normally.

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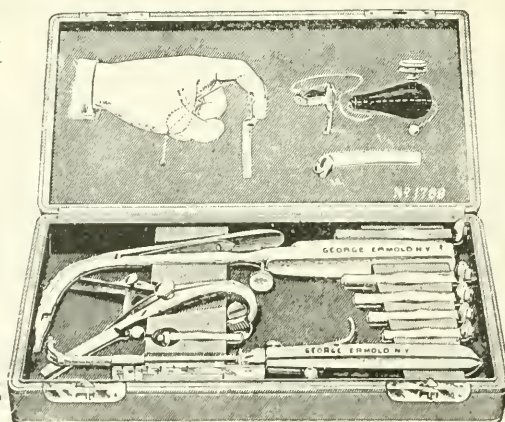
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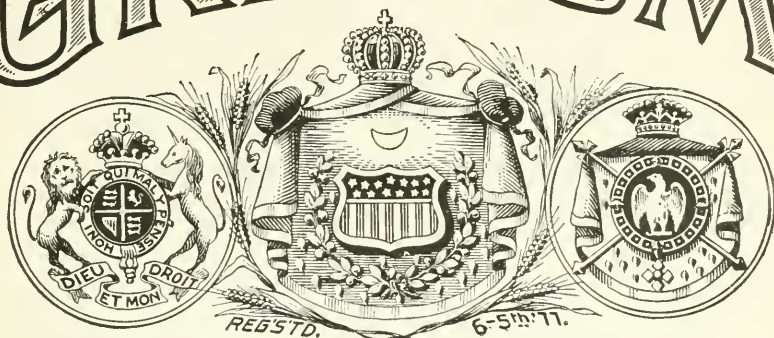
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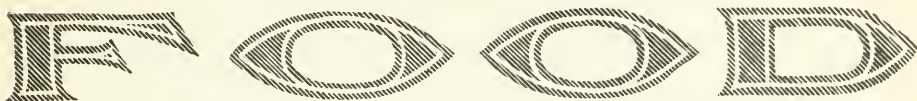
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